



**Harvard Pilgrim First Seniority Open Enrollment Form
Medicare and Non-Medicare Combination Coverage**

Insured's GIC-ID (usually Soc. Sec. #) Sex: Male ☐ Female ☐ Date of Birth ____/____/____
- -

Name (Last) _____ (First) _____ (MI) _____

Address _____

City _____ State ____ Zip code _____

Home Phone _____

Complete this section if you as the insured are under age 65 and not enrolled in a Medicare plan and your spouse is over age 65 and enrolled in a Medicare plan. Please also sign where noted on page two.

_____ I want to enroll in the (check one):

- ☐ Commonwealth Indemnity Plan Basic with CIC (Non-Medicare).
☐ Commonwealth Indemnity Plan Basic without CIC (Non-Medicare)
☐ Commonwealth Indemnity Plan Community Choice (*RMTs not eligible*)
☐ Commonwealth Indemnity Plan PLUS (*RMTs not eligible*)

Please enroll my spouse and/or dependent in the Commonwealth Indemnity Plan Medicare Extension (OME) (check one):

_____ I want to enroll in the Harvard Pilgrim Independence Plan. (Please enroll my spouse and/or dependent in the Harvard Pilgrim First Seniority Freedom Plan. I will contact Harvard Pilgrim and complete the Medicare enrollment form.) - *RMTs not eligible for this coverage combination.*

_____ I want to enroll in Navigator by Tufts Health Plan. Please enroll my spouse and/or dependent in:
Check one: Tufts Medicare Complement _____ Tufts Medicare Preferred _____
(I will contact Tufts and complete the HMO Medicare enrollment form.) *RMTs not eligible for this coverage combination.*

_____ I want to enroll in the _____ HMO Plan.
(Please enroll my spouse and/or dependent in the HMO's Medicare Plan. I will contact the HMO Plan and complete the HMO's Non-Medicare and Medicare enrollment forms.)

Complete this section if you as the insured are over age 65 and enrolled in a Medicare plan and your spouse is under age 65 and not enrolled in a Medicare plan. Please also sign where noted on page two.

_____ I want to enroll in the Commonwealth Indemnity Plan Medicare Extension (OME) (check one):

- ☐ with CIC
☐ without CIC

Please enroll my spouse and/or dependent in the (check one):

- ☐ Commonwealth Indemnity Plan Basic (Non-Medicare).
☐ Commonwealth Indemnity Plan Community Choice (*RMTs not eligible*)
☐ Commonwealth Indemnity Plan PLUS (*RMTs not eligible*)

(options continued on page two)

(options continued from side one)

_____ I want to enroll in the Harvard Pilgrim First Seniority Freedom Plan.
(Please enroll my spouse and/or dependent in the Harvard Pilgrim Independence Plan. I will contact Harvard and complete the Medicare enrollment form.) *RMTs not eligible for this coverage combination.*

_____ I want to enroll in (check one) ☐ Tufts Medicare Complement ☐ Tufts Medicare Preferred
(Please enroll my spouse and/or dependent in Navigator by Tufts Health Plan. I will contact Tufts and complete the Medicare enrollment form.) *RMTs not eligible for this coverage combination.*

_____ I want to enroll in the _____ HMO Medicare Plan.
(Please enroll my spouse and/or dependent in the Non-Medicare HMO Plan. I will contact the Plan and complete the Medicare and non-Medicare HMO enrollment forms.)

Signature of GIC Insured: _____ Date: _____

Print name of GIC Insured: _____ Print Insured's Soc. Sec. No. _____

RETURN FORM NO LATER THAN OCTOBER 27, 2006 TO: GIC, PO BOX 8747, BOSTON, MA 02114-8747
Your new coverage will be effective January 1, 2007

FORM-FIRSTSENMIXED 9/06